Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Keep These 6 Essential Coding Tips in Mind for 2012

Ring in the New Year without a hitch by implementing these simple strategies.

As your practice prepares for the calendar to turn to 2012, you want to ensure a smooth transition while continuing to collect your reimbursement. Follow these simple tips to ensure that Jan. 1 doesn't throw a wrench into your coding systems.

1. Look to new code G0444 for depression screening. Effective Oct. 14, 2011, Medicare now reimburses depressing screenings for Medicare patients, as we reported in Vol 12, No. 41 of the Insider. To collect your due for this service, you'll report G0444 (Annual depression screening, 15 minutes) to your MAC. Deductibles and coinsurance do not apply to these services.

To read more about Medicare's coverage of depression screening, check out CMS Transmittal 2359 at www.cms.gov/transmittals/downloads/R2359CP.pdf.

2. Keep an eye on CPT®'s 'errata. Everyone makes mistakes--even the AMA--and the organization lists CPT® 2012 errors on its Web site (www.ama-assn.org/resources/doc/cpt/cpt-2011-corrections.pdf) so you can find out which codes require corrections in your new CPT manual.

For example: At the request of many physicians, CPT® 2012 now defines the term "other qualified healthcare professional." Although this definition didn't make it into the 2012 manual, the AMA lists it as part of the "CPT® 2012 Errata" on its Web site and the definition is as follows:

"A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service. Other policies may also affect who may report specified services."

This example only scratches the surface of CPT®'s errata for the coming year. In fact, the online listing includes a full 13 pages of corrections, so don't miss the AMA Web site to research all of the changes you should implement before Jan. 1.

3. Performing anesthesia in critical access hospital? Get to know modifier 'AA.' If you bill anesthesia services on behalf of a provider through a Method II critical access hospital (CAH), your bottom line could improve starting in January 2012.

Background: Anesthesiologists who provide services in a Method II CAH (sometimes referred to as CAHs that have elected the "optional" method) have the option of reassigning their billing rights to the CAH. The CAH then submits a bill with revenue code 0963 (Professional fees for anesthesiologist [MD]) to receive pay for anesthesia services. When the service is reported with modifier AA (Anesthesia services performed personally by anesthesiologist), CMS currently calculates pay based on a 20 percent reduction of the fee schedule amount before calculating deductible and coinsurance.

Change: CMS transmittal 2268 dated August 1, 2011, removes the 20 percent reduction when calculating payment for these services. The change takes effect January 3, 2012.

Supporting information with the transmittal explains that "when a medically necessary anesthesia service is furnished

within a HPSA [health professional shortage area] area by a physician, a HPSA bonus is payable. ... Pay physicians the HPSA bonus when CPT® codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and 'QB' or 'QU' in revenue code 963."

4. Don't report nerve block codes 64490-64495 unless physician uses imaging. Although CPT® 2012 did not change the descriptors for these paravertebral facet joint injection codes, it did add an important notation in the introductory notes.

"Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495," the new notation says. "If imaging is not used, report 20552-20553."

Auditors will be watching: The CPT® notation about this situation is important to remember because auditors are sure to keep an eye on this issue going forward. **Why?** Trigger point codes 20552-20553 pay between $52 and $59--whereas nerve block code 64490 reimburses a hefty $196. Therefore, if you miscode this service even ten times a year, you're collecting almost $1,500 more than you deserve.

5. Know what makes a new patient. CPT®'s definition of a "new" patient changes slightly for 2012, with the CPT® manual stating, "A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." The portions of the description that are new for 2012 are underlined.

What this means to you: If your practice employs various subspecialists, CPT® now makes it clear that claims for patients who see different doctors with different subspecialties can be billed using a new patient code (such as 99201-99205).